Medicare Learning Network
MLN Matters
CMS CENTERS for MEDICARE & MEDICAID SERVICES
Information for Medicare Fee-for-Service Health Care Professionals

Related Change Request (CR) #: 4056 MLN Matters Number: MM4056
Related CR Release Date: October 14, 2005
Related CR Transmittal #: 38
Effective Date: January 14, 2006
Implementation Date: January 14, 2006

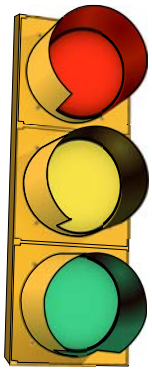
Hospital Audit Workload Updates Related to Medicare Secondary Payer

Note: This article was revised to contain Web addresses that conform to the new CMS web site and to show they are now MLN Matters articles. All other information remains the same.

Provider Types Affected

Hospitals billing fiscal intermediaries (FIs)

Provider Action Needed



STOP – Impact to You

This article is based on Change Request (CR) 4056, which updates the hospital audit sections in Chapter 5 of the *Medicare Secondary Payer Manual* (Pub. 100-05).

CAUTION – What You Need to Know

CR4056 clarifies the workload expectations for FIs having multiple states for which they have claims processing responsibility. *CMS wants to ensure that a facility is not audited multiple times by multiple contractors because of the contractor presence in the state.*

GO – What You Need to Do

See the *Background* section of this article for further details regarding these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) issued CR4056 to provide the following updates to the hospital audit sections of the *Medicare Secondary Payer Manual*, Chapter 5 (Contractor Prepayment Processing Requirements), Section 70 (Hospital Review Protocol for Medicare Secondary Payer):

- It clarifies the workload expectations for a Medicare contractor having multiple states for which they have claims processing responsibility; and
- It replaces references to “fiscal intermediary” with “contractor” in preparation for the implementation of Medicare Contracting Reform provision of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).

CR4056 instructs Medicare contractors to:

- Conduct reviews on 10 percent of the hospitals (or a maximum of 20, whichever is the lesser of the two) in each state for which they have Medicare claims processing responsibility;
- Select samples of claims from two months of the hospital's processed claims history; and
- Provide a listing of claims selected for review within 15 days of the date of initial notice of the review.

Note: Multiple contractors having a presence in one state are instructed to communicate with each other to ensure that duplicate reviews do not occur and multiple contractors do not review more hospital providers (as a combined total) than would have been reviewed if only one contractor processed claims for all hospital providers in that state.

Implementation

The implementation date for the instruction is January 14, 2006.

Additional Information

For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed at http://www.cms.hhs.gov/transmittals/downloads/R38MSP.pdf on the CMS web site.

If you have any questions, please contact your intermediary at their toll-free number, which may be found at http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.pdf on the CMS web site.